STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
Poc #1	445291	A. BUILDING _____ B. WING _____	C 06/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ERWIN HEALTH CARE CENTER	100 STALLING LANE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	Resident # 5 was discharged from the facility on November 28, 2011. All policies relating to alleged or suspected case of mistreatment, neglect, injuries of unknown source or abuse will be reviewed by the Quality Assurance Committee on July 26, 2012 and revise if necessary. All allegations or suspected cases of mistreatment, neglect, injuries of unknown source or abuse will be reported in a timely manner to all persons or agencies including the state licensing/certification agency responsible for surveying/licensing the facility. These reports will be completed by the Director of Nursing. All allegations or suspected cases of mistreatment, neglect, injuries of unknown source or abuse will be reviewed by the Quality Assurance Committee on a monthly basis. The Quality Assurance Committee members include the Administrator, Assistant to the Administrator, Medical Director, Director of Nursing, Pharmacist, MDS Coordinator, Rehab Director, Social Services Director, and QA Nurse. When areas of focus and trends are identified, action plans well be developed and follow-up will be completed.	7/27/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Troy Gadsby — TITLE: Administrator — (X6) DATE: 7/5/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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ERWIN HEALTH CARE CENTER	100 STALLING LANE ERWIN, TN 37650

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of State of Tennessee Department of Human Services Adult Protective Services (APS) documentation, review of the facility investigation, facility policy review and interview, the facility failed to report allegations of neglect to the State agency. The findings included: Resident #5 was admitted to the facility on March 3, 2011 with diagnosis including Pneumonia with Atelectasis, Schizophrenia, Encephalopathy, Renal Disease, Anxiety, Dementia, Paroxysmal Atrial Fibrillation, Chronic Mental Illness and Organic Brain Syndrome. Medical record review of the Minimum Data Set (MDS) dated September 19, 2011 revealed the resident had short and long-term memory problems and severely impaired decision-making skills; was totally dependent on staff for all activities of daily living (ADLS); had a feeding tube; had limitations in range of motion in the arms and legs; and was incontinent of bowel and bladder. Medical record review of a nurse's note dated November 28, 2011 revealed, "...Lungs coarse. Suctioned...Light tan sputum obtained...temp (temperature) 101.3 Fahrenheit...(Physician) notified that (family) wants (resident) to go to hospital. Order received..." Continued review revealed the resident was transferred to the hospital on November 28, 2011. Continued review revealed the resident did not return to the	F 225		

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ERWIN HEALTH CARE CENTER	100 STALLING LANE ERWIN, TN 37650

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F 225	Continued From page 2 facility after the hospital stay. Review of a document provided by the facility entitled "State of Tennessee Department of Human Services Adult Protective Services, Report of Alleged Abuse, Neglect or Exploitation of an Adult dated January 9, 2012 revealed allegations of neglect had been reported to Adult Protective Services (APS). Review of the APS document revealed the allegations included, "...(Resident #5) was left in...hot room, soaked with urine and feces...had two fingers swollen (on right hand) and both were black in color...(Referent) wants something done about the negligence of (facility) staff investigated...(resident) was subjected to being extremely neglected...supposed to be on a blood thinner when...first entered the nursing home but wasn't for awhile. On three occasions (resident) was running high temperatures (fevers) and staff were not aware of it, until a family member brought it to staff's attention. On the twenty eighth of November (resident) had to be taken to the emergency room due to aspiration pneumonia...could not breathe and was turning blue. (Referent) stated if a...family member had not shown up that day, (resident) would have died that day..." Review of the facility's investigation of the alleged neglect revealed the facility did not substantiate the allegations of neglect. Continued review revealed no documentation the facility reported the allegations to the State survey agency. Telephone interview on February 2, 2012 at 9:30 a.m., with the APS worker revealed APS did not investigate the allegations as the resident had	F 225		

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F 225	Continued From page 3 been discharged to another facility at the time APS received the allegations. Review of the facility's policy entitled "Reporting Abuse to Facility Management" revealed, "...When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility administrator, or is/her designee, will notify the following persons or agencies of such incident...The state licensing/certification agency responsible to surveying/licensing the facility..." Interview on June 18, 2012 at 10:45 a.m., with the Assistant to the Administrator and the Director of Nursing confirmed in January 2012 a police officer came to the facility and provided a copy of the APS document (noted above) to the facility. Continued interview confirmed the facility failed to report the allegations of neglect to the State survey agency.	F 225		
F 333 SS=D	C/O #29208 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of manufacturer's recommendations and interview, the facility failed to ensure a significant medication error did not occur when a capsuled medication was opened prior to administration and administered via a feeding tube for one (#5)	F 333	Resident # 5 was discharged from the facility on November 28, 2011. All residents in the facility that are currently receiving pradaxa are taking the medication orally and the medication is not crushed and the capsule is not opened. The medication is swallowed whole. Policies and procedures relating to administration of pradaxa will be reviewed and revised if necessary. This review and revision will be completed by the Quality Assurance Committed on July 26, 2012. A repeat In-service was completed on June 19, 2012 for all RN's and LPN's relating to the appropriate administration of pradaxa. The In-Service was also completed on June 21, 2012 for those who were unable to attend June 19, 2012.	7/27/12

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 333	Continued From page 4 of six residents reviewed. The findings included: Resident #5 was admitted to the facility on March 3, 2011 with diagnosis including Pneumonia with Atelectasis, Schizophrenia, Encephalopathy, Renal Disease, Anxiety, Dementia, Paroxysmal Atrial Fibrillation, Chronic Mental Illness and Organic Brain Syndrome. Medical record review of the Minimum Data Set (MDS) dated September 19, 2011 revealed the resident had short and long-term memory problems and severely impaired decision-making skills; was totally dependent on staff for all activities of daily living (ADLS); and had a feeding tube. Medical record review of physician's orders dated September 12, 2011 revealed all of the resident's medications were administered through the feeding tube. Medical record review of a nurse's note dated October 21, 2011 revealed, "...Meds (Medications) taken via G-tube (Gastrostomy) (without) difficulty..." Medical record review of a nurse's note dated November 12, 2011 revealed, "...Peg (Percutaneous Endoscopic Gastrostomy) tube is patent...flushes well (after) meds..." Medical record review of a physician's order dated November 14, 2011 revealed, "DC (Discontinue) Coumadin (blood thinner). Start Pradaxa (blood thinner) 150 mg (milligrams) BID (twice daily)."	F 333	An audit will be completed by the QA Nurse on all residents that have an order for Pradaxa to confirm that residents can swallow the medication whole. This audit will be completed on an ongoing basis for each resident who has a new order written for pradaxa. When a resident is placed on a feeding tube, the QA Nurse will review medications, which are administered, via the tube to validate appropriateness of administration of the medications. The audit will be reviewed by the Quality Assurance Committee. The members include the Administrator, Assistant to the Administrator, Medical Director, Director of Nursing, Pharmacist, MDS Coordinator, Rehab Director, Social Services Director, and QA Nurse. When areas of focus and tends are identified, action plans will be developed and follow up will be completed.	

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F 333	Continued From page 5 Medical record review of the Medication Administration Record (MAR) dated November 1-30, 2011 revealed Pradaxa (dabigatran etexilate) was administered twice daily November 1-28, 2011. Review of manufacturer's recommendations for Pradaxa revealed, "...It is important to know that Pradaxa can cause bleeding which can be serious and sometimes lead to death. This is because Pradaxa is a blood-thinning medicine (anticoagulant) that lowers the chance of blood clots forming...The oral (by mouth) bioavailability...increases by 75% (percent) when the pellets are taken without the capsule shell compared to the intact capsule formulation. Pradaxa capsules should therefore not be broken, chewed, or opened before administration..." Review of an inservice training for nurses dated December 5, 2011 revealed, "Pradaxa-Medication Capsule should always be administered whole. Do not open capsule." Telephone interview on June 18, 2012 at 5:05 p.m., with Licensed Practical Nurse (LPN) #1 who administered Pradaxa to the resident on November 16, 2011 at 8:00 a.m., confirmed LPN #1 opened the capsule of Pradaxa; mixed the Pradaxa with water and the other crushed medications and administered the medications via the feeding tube. Continued interview with LPN #1 revealed LPN #1 "questioned the night shift nurse" about how the Pradaxa should be administered and the night shift nurse reported the physician had been contacted for clarification.	F 333		

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F 333	Continued From page 6 Telephone interview on June 18, 2012 at 6:00 p.m., with LPN #2 confirmed LPN #2 "poured (Pradaxa) from the capsule" into the crushed medications and water and administered the medications via the feeding tube. Telephone interview on June 20, 2011 at 10:05 a.m. with the Director of Nursing confirmed nurses were inserviced not to open Pradaxa capsules after learning the nurses had opened the Pradaxa capsule and administered the pellets via the feeding tube. C/O #29208	F 333	The Plan of Correction (POC) has been developed in compliance with State and Federal Regulation. This plan affirms Erwin Health Care intent and allegation of compliance with regulations. This POC does not constitute an admission or concession of either accuracy or factual allegation made in, or existence or scope of significance, of any cited deficiency	